

**PRE-SERVICE PROVIDER ORIENTATION**

INDIVIDUAL'S NAME (Last, First, M.I.)		ASSISTS NO.	BIRTHDATE				
<b>DIET</b>							
<b>FOOD:</b>							
INDEPENDENT WITH UTENSILS <input type="checkbox"/> Yes <input type="checkbox"/> No		INDEPENDENT WITH SPECIFIC UTENSILS <input type="checkbox"/> Yes <input type="checkbox"/> No					
		REQUIRES LIMITED ASSISTANCE <input type="checkbox"/> Yes <input type="checkbox"/> No					
		REQUIRES SIGNIFICANT ASSISTANCE <input type="checkbox"/> Yes <input type="checkbox"/> No					
DOES FOOD PRESENT A CHOKING HAZARD <input type="checkbox"/> Yes <input type="checkbox"/> No							
		Required consistency of food	<input type="checkbox"/> Normal <input type="checkbox"/> Chopped <input type="checkbox"/> Puréed				
SPECIAL DIET							
TUBE FEEDING (Special instructions required) <input type="checkbox"/> Yes <input type="checkbox"/> No		EATING DISORDER (Describe) <input type="checkbox"/> Yes <input type="checkbox"/> No					
<b>BEVERAGES:</b>							
INDEPENDENT WITH ANY CUP/GLASS <input type="checkbox"/> Yes <input type="checkbox"/> No		INDEPENDENT WITH ADAPTIVE <input type="checkbox"/> Yes <input type="checkbox"/> No					
		REQUIRES LIMITED ASSISTANCE <input type="checkbox"/> Yes <input type="checkbox"/> No					
		REQUIRES SIGNIFICANT ASSISTANCE <input type="checkbox"/> Yes <input type="checkbox"/> No					
INDEPENDENT IN OBTAINING/REQUESTING BEVERAGES <input type="checkbox"/> Yes <input type="checkbox"/> No							
Describe adaptive eating/drinking equipment							
IF SPECIAL LIQUID INTAKE NEEDS DESCRIBE							
SYSTEM FOR FLUID INTAKE (If applicable)							
<b>COMMUNICATION</b>							
<b>COMMUNICATION SKILLS:</b> (Check as applicable)							
<input type="checkbox"/> Uses complex Sentences <input type="checkbox"/> Uses simple sentences		<input type="checkbox"/> Signs <input type="checkbox"/> Nods yes/no <input type="checkbox"/> Gestures					
DESCRIBE AUGMENTATIVE COMMUNICATION DEVICES (If applicable)							
<b>MOBILITY</b>							
<b>BALANCE WHILE STANDING</b>							
<input type="checkbox"/> Excellent (not an issue) <input type="checkbox"/> Moderate (stumbles, etc)		<input type="checkbox"/> Poor (very unsteady; falls)					
UTILIZES ADAPTIVE AIDS FOR BALANCE <input type="checkbox"/> Yes <input type="checkbox"/> No							
INDEPENDENT MOBILITY (Check as applicable)							
<input type="checkbox"/> Crawling/scooting <input type="checkbox"/> Kneeling <input type="checkbox"/> Standing		<input type="checkbox"/> Walking <input type="checkbox"/> Running <input type="checkbox"/> Climbing					
MOBILITY/BALANCE AIDS (Check as applicable)							
<input type="checkbox"/> N/A <input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Crutches <input type="checkbox"/> AFOs <input type="checkbox"/> Leg Braces <input type="checkbox"/> Wheelchair <input type="checkbox"/> Other (Specify)							
POSITIONING INSTRUCTIONS		LIFTING/CARRYING INSTRUCTIONS					
<b>PERSONAL CARE SKILLS</b> (Check all applicable items)							
	DRESSING	TOILETING	BATHING	DENTAL CARE	MENSES	MED. ADMIN.	OTHER
Independent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Requires Prompting/reminding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Requires Limited assistance/ supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Requires significant assistance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IF APPLICABLE, DESCRIBE SPECIAL PERSONAL CARE NEEDS AND PREFERENCES							
<b>BEHAVIORAL CONCERNs (If applicable)</b>				CIT Training	<input type="checkbox"/> Yes <input type="checkbox"/> No		
BRIEF DESCRIPTION		APPROXIMATE FREQUENCY		RECOMMENDED INTERVENTION			
Aggression							
Self-Injurious Behavior							
Property Destruction							
AWOL							
Self Stimulation							
Sexual Acting Out							
Other							
IS A BEHAVIOR TREATMENT PLAN AVAILABLE FOR ADDITIONAL INFORMATION <input type="checkbox"/> Yes <input type="checkbox"/> No				REASON FOR BTP			
METHOD USED TO OBTAIN INFORMATION (In person, case file, etc)							
<b>SIGNATURES</b>							
SIGNATURE OF PERSON COMPLETING IF NOT RESPONSIBLE PARTY		RELATIONSHIP				DATE	
PRINT PROVIDER'S NAME		PROVIDER'S SIGNATURE				DATE	
PRINT RESPONSIBLE PERSON/GUARDIAN'S NAME		RESPONSIBLE PERSON/GUARDIAN'S SIGNATURE				DATE	

Distribution: White – HCBS Provider; White – HCBS District Office; Canary – Parent/Guardian; Pink – Support Coordinator  
See reverse for EOE/ADA Disclosures

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